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ABSTRACT

The relationship between religiosity and the knowledge, attitudes, and practices of long-term care staff related to elderly sexuality was investigated. Participants were 127 long-term care staff recruited at 8 sites in Oklahoma, Michigan, Virginia, California, and Maryland. Participants' positions included nurses, housekeepers, administrators, and other support personnel. The survey used in the study was designed to be an evaluation instrument for staff training materials and so items were criterion-referenced to the training objectives. The study team developed 159 forced choice items (agree/disagree) that were assigned to 1 of 4 forms, each of which also included a 2-page questionnaire asking participants to provide information about age, gender, educational level, ethnicity, religiosity, political philosophy, marital status, health, and whether they were currently in a sexually intimate relationship. Analysis indicated significant differences related to religiosity occurred for 15 of the 159 items. Religiosity was not a significant predictor of total score or scores on the knowledge, attitudes, and practices subtests for the entire group or for African American and white subpopulations. Further research was suggested to replicate these findings on other populations of long-term care staff. (Appendixes include 10 data tables and the instrument.) (YLB)

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The Relationship Between Staff Religiosity and Attitudes Toward Elderly Sexuality

Bonnie L. Walker, PhD[1]

ABSTRACT. This study examines the relationship between religiosity and the knowledge, attitudes, and practices of long-term care staff related to elderly sexuality. In this group of 127 long-term care staff, significant differences related to religiosity occurred for 15 of the 159 items included in the survey. Religiosity was not a significant predictor of total score or scores on the knowledge, attitudes, and practices subtests for the entire group or for African American and white subpopulations. Further research is needed to replicate these findings on other populations of long-term care staff. This information is useful when planning and conducting training on sexuality with staff.

KEYWORDS: Aging, Religiosity, Attitudes, Sexuality, Long-term care staff

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INTRODUCTION

The attitudes and actions of staff of long-term care facilities directly impact on the expression of sexuality by the elderly residents (Eddy, 1986). Studies have consistently found that nursing staff have insufficient knowledge about elderly sexuality and that their attitudes tend to be more negative than positive. Educational programs that increase staff knowledge of elderly sexuality, however, have been shown to bring about more positive attitudes (Luketich, 1991; Quinn-Krach & Van Hoozer, 1988).

Although knowledge about sexuality is the variable that is most often investigated in studies of staff attitudes toward elderly sexuality, it is likely that other variables have an impact on both existing attitudes and on willingness to change. If so, these characteristics need to be considered when developing a staff training program. One variable of interest is the religiosity of staff. Frazer and her colleagues (1982) in a study of the effects of a human sexuality workshop on knowledge and attitudes found that nursing students who described themselves as very religious were less likely to report changes in their attitudes following their participation. Other studies have also found that African Americans tend to be more permissive on sexual issues and that their views appear not to be related to how religious they are (Weinberg & Williams, 1988).

As part of a curriculum development project for long-term care staff aimed at increasing knowledge and encouraging tolerant attitudes and proactive behaviors regarding elderly sexual expression, we investigated the relationship between religiosity and knowledge, attitudes, and practices in a group of long-term care staff. We also explored the relationship between religiosity, ethnicity and those same variables. We hypothesized that religiosity would play a role in the knowledge, attitudes, and practices of long-term care staff as related to elderly sexuality. The purpose of this paper is to report the findings of this study.

METHODS

Study Population

The participants in this study were 127 long-term care staff recruited at eight sites located in Oklahoma, Michigan, Virginia, California, and Maryland. The types of facilities represented were a life care community, a nursing facility, residential care homes, assisted living facilities, and adult foster care homes. The participants' positions at these facilities included nurses, housekeepers, administrators, and other support personnel. Their mean age was 40.25 (SD = 12.9). The majority (60%) were married. When asked if they were currently in a sexually intimate relationship, 73% said "yes." African Americans (42%) and whites (44%) were represented about equally in this group. The remaining participants were American Indians, Asians, and Other. Virtually all (98.5%) were high school graduates. Most of the group (59%) had some post high school

education: 17% of the population held a baccalaureate degree. Of those with baccalaureate degrees, 9.5% also had a graduate degree. Politically they described themselves as conservative (26%), liberal (30%), and independent (37%); 7% did not respond to the question. The majority (59%) described their health as good, with 32% describing their health as excellent and the rest as fair. None of the participants described their health as poor.

Religiosity was a three-level ordinal variable measured by the question, "How religious are you?" The response categories were 1 = Very religious; 2 = Somewhat religious; and 3 = Not religious. The majority of the participants (71%) said they were "Somewhat religious." Only 20% said they were "Very religious" and 6% said they were "Not religious." The remaining participants (3%) did not respond to this question.

The participants were also asked to identify their religious affiliation. The instructions said to write "none" if they were unaffiliated. The majority (61%) named a Protestant denomination; 5.5%% were Catholic; and 1.5% were Jewish. Of the remaining participants, 12.5% wrote "none," and 19% left the item blank. The most common Protestant denominations named were: Baptist (34), Episcopal (14), Methodist (10), and Pentecostal (4). Also, 15 wrote "Christian," and 15 wrote "Protestant." Other denominations named at least once were Mormon, Assembly of God, Unitarian, Church of God, and Jehovah's Witness.

In a previous study (Walker & Osgood, 1997) the distribution of another population of long-term care staff (N=97) was found to be similar: 24.2% identified themselves as very religious, 65.7% somewhat religious, 5.1% not religious and 2% not responding. This group had a higher percentage of white staff (79%) and fewer African Americans (5.1%) than the present study.

The Survey Instrument

The survey used in this study was designed to be an evaluation instrument for staff training materials and so items were criterion-referenced to the training objectives. Prior to developing the items for the survey, we conducted a comprehensive literature review (Walker, 1997). A team consisting of a gerontologist, a social worker, a geriatrician, a registered nurse, and a long-term care administrator developed and evaluated training objectives related to elderly sexuality. In addition to the information from the literature review and personal experience, we conducted focus group discussions with groups of long-term care staff, residents, and family members. We also conducted a survey of staff from several long-term care facilities to determine their reactions to a preliminary set of objectives (Walker & Osgood, 1997). Table 1 lists the set of training objectives.

Insert Table 1 about here.

Next, the team developed 159 forced choice items (agree/disagree) designed to measure knowledge, attitudes, and practices related to the training objectives. In addition to those 159 items, the survey included a two page questionnaire asking participants to provide information about age, gender, educational level, ethnicity, religiosity, political philosophy, marital status, health, and whether they were currently in a sexually intimate relationship.

The 159 items were assigned to one of four forms so that each form had approximately the same number of items matching each objective and within each group of items each form had the same number of items measuring knowledge, attitudes, or practices. Form 1 had 42 items; Form 2 had 38 items; Form 3 had 39 items; and Form 4 had 40 items. A copy of the survey is included as Appendix A.

Procedures

During April and May 1997, coordinators at each of the eight participating sites distributed a letter to the study participants explaining the purpose of the project. They also distributed a copies of the survey instrument. Participants at each site completed equal numbers of each of the four survey forms. The directions on the form were: "Read each statement. Then circle Agree or Disagree." Most participants completed the survey in 15 minutes or less.

Data Analysis

Responses were entered into an Excel file and analyzed using SPSS. Results were calculated for all survey items and for the three subtests: knowledge, attitudes, and practices. Because the number of items varied from form to form, raw scores were converted to percentages for comparison. Correct/Incorrect responses were determined by the project advisory group based on scientific information for knowledge items, a determination of whether "agree" or "disagree" reflects a more tolerant perspective for attitude items, and a determination that the response reflects support of proactive staff responses toward elderly sexuality and sexuality in general. A higher score on this scale, therefore, reflected greater knowledge of elderly sexuality, more tolerant attitudes toward elderly sexuality, and a more proactive posture toward staff responses toward expressions of elderly sexuality and elderly sexuality in general.

FINDINGS

Relationship between Survey Scores and Religiosity

The first question was whether or not religiosity was related to the participants' mean scores on the survey as a whole and on each of the subtests. An analysis of variance was used to compare mean scores for the total survey and for each of the subtests on knowledge, attitudes, and practices with levels of religiosity. The results showed that religiosity was not a significant predictor regarding the participants' total survey score or for any of the three subtest scores. See Tables 2 to 5.

Insert Tables 2 to 5 about here.

Items Related to Religiosity

There were 159 items distributed among the four forms. An analysis of variance demonstrated that the four groups were not significantly different regarding religiosity, but because so few of the participants had said they were "Not religious," this response category does not appear among the group who completed Form 3 and therefore was omitted from statistics provided for the group.

A Pearsonian chi-square analysis was performed for each item to determine whether there was a significant relationship between responses (agree or disagree, or no response) and the degree of religiosity. A significant relationship was found for 15 items, 3 items on Form 1, 7 items on Form 2, and 5 items on Form 3. No significant differences related to religiosity were observed for any of the items on Form 4. The greatest number of differences were observed on the items on Form 3.

Whether significant relationships were more likely to occur for knowledge, attitude, or practice items was also of interest. A post hoc analysis of the findings shows that the 15 significant relationships were divided nearly evenly among the three types of items, e.g., 4 knowledge items, 5 attitude items, and 5 practices items. Differences were most often related to the health issues (5 of 15) and dementia (4 of 15) objectives. Only one item related to homosexuality appeared on the list. For that item, the very religious staff were more tolerant than the somewhat religious group.

There was no clear pattern regard the direction of difference for the 15 items where differences were related to religiosity, e.g., Were the very religious more or less knowledgeable, tolerant, or proactive? The very religious participants were more proactive or tolerant on 7 of the 15 items (F1-5, F2-6, F2-9, F2-19, F3-3, F3-6, F3-15). The participants disagreed most sharply on Item F1-24 which stated that "Staff should encourage relationships between residents." None of

the "very religious" participants agreed with that item, but 7 of the "somewhat religious" participants agreed.

Only one respondent, a "not religious" person, agreed with the statement that "Sex between older people of different races is wrong." One of the very religious respondents did not respond to that question. The very religious respondents showed their reluctance to get actively involved in the sexual expression of the elderly by disagreeing with the statement "Staff should reassure residents with health problems that sexual expression is still possible." They agreed less often with the statement "When it comes to resident sexuality, staff must judge each situation individually." The very religious group who completed Form 2 agreed more strongly than the somewhat religious group with F2-18, "A person who is not mentally competent should not be allowed to get romantically involved with another person." In contrast, the very religious people who completed Form 3 disagreed rather strongly with F3-25 which stated that "A person with dementia should not be having sex." The group of very religious people who completed Form 2 were slightly less tolerant than the somewhat religious group (60% to 66%) on the item which said "Staff should respect the gay or lesbian residents' right to privacy." Very religious participants were also less tolerant on F3-13 which stated that "A person with a colostomy may worry about loss of sexual attractiveness." Table 6 lists each of the survey items significantly related to religiosity.

Insert Table 6 about here.

Religious Affiliation

Participants were also asked to identify their religious affiliation. Responses were coded as either Protestant, Catholic, Jewish, None, or No Response. An analysis of variance was used to determine if religious affiliation was related to the participants' mean scores on the total survey or on any of the subtests. Differences among the groups approached significance for the total score ($F=2.35$, $p=.0580$), however, none of the subtest scores were significantly related to religious affiliation. Participants identifying themselves as Catholic had the highest total score and participants who had not responded to the question had the lowest score. See Tables 7 to 10.

Influence of Ethnicity

Because previous research (Weinberg & Williams, 1988) suggested that religiosity is less of an influence for African Americans than for whites in the United States and because nearly half of the population was African American, ANOVA was used to determine if there were significant differences for total scores, and scores on each subtest related to ethnicity. Again, religiosity was not related to the total score or any subscore for either African American (N=52) or white (N=56) staff. Although differences between African Americans and whites were not significant, the

number of participants describing themselves as not religious was not large enough to make meaningful comparisons. (There was one African American who described himself or herself as not religious as compared to seven white staff.)

DISCUSSION

The results of this study suggest that that the degree of religiosity of nursing facility staff would not play an important role in their knowledge, attitudes, and practices related to elderly sexuality. The data indicate, however, that long-term care staff by and large see themselves as religious. A very small number of respondents indicated that they were "not religious" even though a larger number were not affiliated with a specific religious denomination.

Of the 159 items, responses to only 15 appear to be related to religiosity. Analysis of the results indicates there is no clear pattern as to the type of influence religiosity might have. In some cases the very religious were more tolerant and in some cases less tolerant. Religiosity was not related to knowledge, attitudes, or practice items related to either masturbation and homosexuality, two topics on which we might most expect to see a relationship.

Also, ethno-racial identity did not appear to be related to the attitudes toward elderly sexuality of the staff in this population. It could be that other factors, e.g., working with the elderly in long-term care, have a greater influence on knowledge, attitudes, and practices than ethno-racial background.

Limitations

The question of using the question "How religious are you?" with a heterogeneous population will certainly be raised. On at least some variables there are insurmountable differences between various denominations. This study group was comprised only of Protestants, Catholics, and Jews. None of the participants reported membership in groups such as Muslims, Buddhists, Hindus, and others. However, a substantial number did not answer the question asking them to name their religious affiliation nor did they write "none" as they were instructed to do. The small population sizes of Catholics and Jews, due to distributing 127 participants over four survey forms, limits the ability to examine subpopulations, e.g., Protestants, Catholics, Jews for religious effect. The relationship between total score and religious affiliation, however, approached significance and warrants further investigation.

Another limitation of the study is the dichotomous scale that prevents measuring the strength of agreement and disagreement with the survey statements. The disadvantage is balanced against the advantage of simplifying the scale for the respondents. In previous studies the

researchers had encountered a great deal of resistance when staff were asked to complete a five-point Likert-type scale.

Another limitation of this study and its findings may be the small number of staff who identified themselves as very religious and the even smaller number who said they were not religious. However, we have no reason to believe that this distribution is not typical of the larger population of long-term care staff. In the next version of the survey, the question will be reworded to say, "How religious or spiritual are you?"

Some of the survey items also may lack face validity even though the process used to develop the survey items consisted of review by the expert team on several occasions and use of the comprehensive literature review as a source for many of the items. Survey items that showed weak discrimination and poor reliability will be omitted from future versions of the survey and the revised survey will undergo further testing.

Despite these limitations, however, the study findings are important as the researchers move forward toward refining the survey instrument and designing the training program.

Application of Results

The next step in this project will be to reduce the number of items in the survey by half and create two new forms which will be tested with another population of long-term care staff.

With respect to the curriculum that under development, based on these findings, religious issues, especially prohibitions related to masturbation and homosexuality, do not appear to have influenced this population of long-term care staff with respect to the knowledge they have acquired, the attitudes they have developed, nor their views regarding the appropriate responses of staff. Whether religiosity affects their ability to change is another issue that remains to be investigated. Sensitivity to the religious beliefs of the staff, however, remains an important consideration as we develop this curriculum.

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TABLE 1. Sexuality and the Elderly: Revised Training Objectives*

1. Define terms such as intimacy and sexuality and identify a variety of types of sexual expression and behaviors available to older people.
2. Identify age-related changes and health problems that affect sexual desire and/or performance including the physical effects of disabilities on the ability to express sexuality, stereotypes related to disabilities, and emotional reactions and beliefs about people with disabilities and their partners and others. Identify effects of medications and other types of drugs (e.g., alcohol, nicotine, illegal drugs) on intimacy, sensuality, and sexuality.
3. Identify resident rights issues related to intimacy, sensuality, and sexuality.
4. Identify the emotional, social and health benefits of intimacy and sexual expression.
5. Distinguish between sexual abuse and consensual sex, identify gray areas, and identify issues related to mental competence and the role it plays in expressing sexuality.
6. Explain the benefits of masturbation and need for self-pleasuring as a means of sexual expression, and identify appropriate responses to resident masturbation both private and public.
7. Identify religious, cultural, generational, and ethnic issues related to intimacy and sexual needs, attitudes, and behaviors.
8. Identify issues related to homosexuality as they relate to residents of retirement communities or long-term care facilities.
9. Identify issues related to families including attitudes toward remarriage, sexual expression outside of marriage, and others that affect elderly expression of sexuality.
10. Identify issues following the death of a spouse for elderly people that prevent seeking intimacy and expressing sensuality and sexuality needs and issues related to an elderly person's need for a willing and able partner or companion.

TABLE 2. Relationship Between Total Sexuality Score and Religiosity

Total Score	Mean %*	S.D	Cases	F	Sig.
Very Religious	67.82	14.98	25	1.61	.1903
Somewhat Religious	71.67	12.25	89		
Not Religious	79.15	14.74	8		
No Response	73.27	13.55	3		
All Cases	71.42	13.11	125		

* The highest possible score was 100%.

TABLE 3. Relationship Between Sexuality Knowledge Scores and Religiosity

Knowledge Score	Mean %*	SD	Cases	F	Sig.
Very Religious	71.33	16.16	25	.6557	.5809
Somewhat Religious	69.42	15.60	89		
Not Religious	77.26	13.86	8		
No Response	69.61	19.13	3		
All Cases	70.31	15.68	125		

* The highest possible score was 100%.

TABLE 4. Relationship Between Sexuality Attitude Scores and Religiosity

Attitude Score	Mean%*	S.D.	Cases	F	Sig.
Very Religious	60.43	15.41	25	1.10	.3513
Somewhat Religious	66.74	17.65	89		
Not Religious	70.36	21.11	8		
No Response	69.61	21.60	3		
All Cases	70.31	17.52	125		

* The highest possible score was 100%.

TABLE 5. Relationship Between Sexuality Practices Scores and Religiosity

Practices Score	Mean%*	SD	Cases	F	Sig.
Very Religious	67.56	19.88	25	2.06	.1091
Somewhat Religious	73.27	17.63	89		
Not Religious	78.79	17.52	8		
No Response	54.86	36.88	4		
All Cases	71.91	19.02	126		

* The highest possible score was 100%.

TABLE 6: Sexuality Survey Items Significantly Related to Religiosity

Item[2]	Agree[3]	Disagree	No Response	X2[4]	p[5]	Statements[6]
F1-5	8 17 2	1 3 0	0 0 1	10.29	.036	Staff should spend time with residents just talking and providing friendship. (P/T)
F1-24	0 7 2	8 12 0	1 1 1	9.62	.047	Staff should encourage relationships between residents. (P/T)
F1-33	0 0 1	8 20 2	1 0 0	12.56	.014	Sex between older people of different races is wrong. (A/F)
F2-6	3 19 0	2 3 0	0 3 1	9.62	.047	Difficulty in getting an erection is the most common sexual problem for men. (K/T)
F2-9	3 16 0	2 7 0	0 2 0	10.14	.038	Health problems are more important to older people than sexual problems. (A/T)
F2-10	2 21 0	3 3 0	0 1 1	21.13	.000	Staff should reassure residents with health problems that sexual expression is still possible. (P/T)
F2-17	3 20 0	2 5 0	0 0 1	31.96	.000	When it comes to resident sexuality, staff must judge each situation individually. (K/T)
F2-18	4 10	1 14	0 0	17.68	.001	A person who is not mentally competent should not be allowed to get romantically involved with another person. (A/F)
F2-19	3 16	2 8	0 1	15.18	.004	Staff should stay out of reach of a demented resident who tries to pinch them. (P/T)
F2-31	3 16	2 5	0 2	10.75	.030	Staff should respect the gay or lesbian residents' right to privacy. (P/T)
F3-3	0 0 0	3 21 4	0 2 0	10.11	.017	People in nursing homes are not interested in sex. (K/F)
F3-6	2 17 1	0 4 3	1 2 0	15.66	.016	Older people in long-term care should get frequent hand and foot massages. (P/T)
F3-13	2 20 3	1 1 0	0 2 1	13.62	.034	A person with a colostomy may worry about loss of sexual attractiveness. (K/T)
F3-15	0 1 0	3 22 4	0 0 0	15.15	.002	It makes no sense for doctors to worry about the sexual needs of their older patients. (A/F)
F3-25	0 9 1	3 14 3	0 0 0	33.04	.000	A person with dementia should not be having sex. (A/F)

[2] Form and item number
[3] Row 1 = Very religious; Row 2 = Somewhat religious; Row 3 = Not Religious
[4] Pearsonian chi-square
[5] Level of significance
[6] K=Knowledge item; A=Attitude item, P= Form and item number
[7] Row Practice item, T=True, F=False

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TABLE 7. Relationship Between Total Sexuality Score and Religious Affiliation

Religious Affiliation	Mean %*	SD	Cases	F	Sig.
Protestant	71.27	13.43	77	2.35	.0580
Catholic	80.66	4.55	7		
Jewish	79.05	12.80	2		
None	75.09	14.35	15		
No Response	66.29	11.19	24		
All Cases	71.42	12.83	125		

* The highest possible score was 100%.

TABLE 8. Relationship Between Sexuality Knowledge Scores and Religious Affiliation

Religious Affiliation	Mean %*	SD	Cases	F	Sig.
Protestant	70.03	14.37	77	1.67	.1610
Catholic	77.49	19.81	7		
Jewish	87.61	7.43	2		
None	73.33	16.43	15		
No Response	65.77	17.16	24		
All Cases	70.31	15.45	125		

* The highest possible score was 100%.

TABLE 9. Relationship Between Sexuality Attitude Scores and Religious Affiliation

Religious Affiliation	Mean %*	SD	Cases	F	Sig.
Protestant	65.55	18.21	77	.9742	.4244
Catholic	70.27	15.74	7		
Jewish	72.38	1.35	2		
None	71.33	19.64	15		
No Response	61.19	14.58	24		
All Cases	65.78	17.54	125		

* The highest possible score was 100%.

TABLE 10. Relationship Between Sexuality Practices Scores and Religiosity

Religious Affiliation	Mean %*	SD	Cases	F	Sig.
Protestant	72.20	17.76	77	1.48	.2134
Catholic	85.90	11.62	7		
Jewish	72.22	39.28	2		
None	72.76	19.10	15		
No Response	66.54	22.09	25		
All Cases	71.42	12.83	126		

* The highest possible score was 100%.

Appendix A
Pretest Items and Findings

A/D/NR	Form	Item and answer key
31/0/1*	F1-1.**	People can fall in love at any age. (1/K/T***)
28/2/2	F1-2.	For most people, the need for intimate relationships exists throughout their lifetime. (1/K/T)
29/1/1	F2-1.	Sexuality includes tenderness, stroking, flirting, and touching. (1/K/T)
15/14/2	F2-2.	All an older person needs for good sex is health and an interested and willing partner. (1/K/T)
27/3/1	F3-1.	Sexual expression is a life-long need. (1/K/T)
21/5/5	F3-2.	Some older people enjoy looking at erotic videos or magazines. (1/K/T)
0/28/3	F3-3.	People in nursing homes are not interested in sex. (1/K/F)
22/8/1	F4-1.	Sexual activities are common in long-term care facilities. (1/K/T)
26/5/0	F4-2.	Sexual expression varies as much among older people as it does among younger people. (1/K/T)
29/2/1	F1-3.	Intimacy is more important than sexual behavior. (1/A/T)
4/25/3	F1-4.	It is not important for staff members to understand the sexual needs of older people. (1/A/F)
28/1/2	F2-3.	People who work in long-term care facilities need to understand their own feelings about sexuality. (1/A/T)
8/22/1	F3-4.	Nursing home staff should not encourage or support sexual activities of any sort by its residents. (1/A/F)
0/31/0	F3-5.	Sexuality is meant for reproduction not for pleasure. (1/A/F)
30/1/0	F4-3.	People past the age of 65 can be sexually attractive. (1/A/T)
27/2/2	F4-4.	People who live in long-term care facilities need opportunities for sexual expression. (1/A/T)
21/7/3	F4-5.	It is okay for older people to look at erotic videos or magazines. (1/A/T)
27/4/1	F1-5.	Staff should spend time with residents just talking and providing friendship. (1/P/T)
1/31/0	F1-6.	Old people who express sexual interest in each other should be separated for their own good. (1/P/F)
26/4/2	F1-7.	Staff members should compliment residents on their physical attractiveness. (1/P/T)
20/9/2	F2-4.	Staff can play an important role in helping residents express their sexuality. (1/P/T)
2/29/0	F2-5.	A man who continuously flirts with nurses should be given a sedative. (1/P/F)
20/7/4	F3-6.	Older people in long-term care should get frequent hand and foot massages. (1/P/T)
8/22/1	F3-7.	I am uncomfortable talking about sex with older people. (1/P/F)
24/7/0	F3-8.	It is appropriate for staff to express affection toward the residents. (1/P/T)
20/9/2	F4-6.	The staff should hug the older people they care for. (1/P/T)
4/24/3	F4-7.	I am not comfortable discussing sexuality. (1/P/F)
24/5/3	F1-8.	Some people in their 80s and 90s are capable of having sexual intercourse. (2/K/T)
7/22/3	F1-9.	After menopause women tend to lose their desire for sex. (2/K/F)

* Agree/Disagree/No Response
** Form and Item Number
*** Objective number, item type (Knowledge, Attitude, Practice), True or False

A/D/NR	A/D/NR	Form Item and answer key
1/30/1	F1-10.	Sexual activity in older people is dangerous to their health. (2/K/F)
15/14/3	F1-11.	Lack of interest is the most common reason for less sexual activity among older women. (2/K/F)
2/26/4	F1-12.	People who have had a stroke are not likely to be interested in sex even after they are feeling better. (2/K/F)
22/5/4	F2-6.	Difficulty in getting an erection is the most common sexual problem for men. (2/K/T)
21/8/2	F2-7.	Loss of a spouse is the most common reason for less sexual activity among older women. (2/K/T)
14/15/2	F2-8.	As people get older they do not desire sex as often. (2/K/T)
22/4/5	F3-9.	Compared to younger women, older women have less vaginal lubrication. (2/K/T)
2/28/1	F3-10.	Older people who are sexually active do not need to use a condom. (2/K/F)
8/22/1	F3-11.	Sexual behavior in people over 65 increases their risk of heart attacks. (2/K/F)
30/1/0	F3-12.	People who have had a stroke may still be interested in sex. (2/K/T)
27/3/3	F3-13.	A person with a colostomy may worry about loss of sexual attractiveness. (2/K/T)
25/1/5	F3-14.	Some antihypertensive medications can cause impaired sexual desire and performance in men and women. (2/K/T)
25/4/2	F4-8.	A person with Parkinson's disease may still be interested in sex. (2/K/T)
6/24/1	F4-9.	A woman's physical capacity for sex declines with age. (2/K/F)
24/6/1	F4-10.	Some antidepressants can decrease sexual desire. (2/K/T)
0/31/0	F4-11.	Older men and women are not [do not find each other] attractive to each other. (2/K/F)
7/22/2	F4-12.	By the age of 70, most men cannot get erections. (2/K/F)
26/6/0	F1-13.	Good health is more important than the ability to have sex. (2/A/F)
4/26/2	F1-14.	A resident who is incontinent should not have a sexual relationship. (2/A/F)
19/9/3	F2-9.	Health problems are more important to older people than sexual problems. (2/A/T)
2/29/0	F3-15.	It makes no sense for doctors to worry about the sexual needs of their older patients. (2/A/F)
15/14/2	F4-13.	It is not appropriate for staff to discuss sex with a resident. (2/A/F)
1/30/0	F4-14.	Sexual changes that occur with age are not important to older people. (2/A/F)
24/7/1	F1-15.	Staff should not be embarrassed to discuss sexuality problems with residents. (2/P/T)
28/4/0	F1-16.	Staff in long-term care facilities have a responsibility to help the older people look attractive. (2/P/T)
22/9/1	F1-17.	Staff should provide information about changes in sexual response to residents when they appear interested. (2/P/T)
23/6/2	F2-10.	Staff should reassure residents with health problems that sexual expression is still possible. (2/P/T)
29/2/0	F2-11.	Staff should be able to recognize side effects of medications. (2/P/T)
31/0/0	F3-16.	Staff should report possible medication side effects. (2/P/T)
27/2/2	F3-17.	Staff should help residents adapt to changes in their health that affect sexual response. (2/P/T)
3/26/2	F4-15.	Staff should help the residents obtain erotic videos or magazines if they ask for them. (2/P/T)
19/12/0	F4-16.	Staff should be willing to talk about sexual concerns with residents. (2/P/T)
31/1/0	F1-18.	People living in long-term care facilities have the right to make decisions about their sexual expression. (3/K/T)

A/D/NR	A/D/NR	Form Item and answer key
30/0/1	F2-12.	People living in long-term care facilities have the right to privacy. (3/ K/T)
31/0/0	F3-18.	Married couples have the right to live together in a nursing facility. (3/K/T)
31/0/0	F4-17.	Older people who live in nursing facilities have the right to privacy. (3/K/T)
16/13/3	F1-19.	People with dementia are not capable of deciding whether or not they want a sexual relationship. (3/A/F)
32/0/0	F1-20.	Married people should be able to live together in a nursing home if they want to. (3/A/T)
23/6/2	F4-18.	An older person is just as capable of making decisions [about what they want] as a younger person. (3/A/T)
31/0/0	F3-19.	Older people deserve the same rights as younger people. (3/A/T)
32/0/0	F1-21.	Staff should knock before entering a resident's room. (3/P/T)
25/4/2	F2-13.	Residents of nursing facilities should be allowed to post "Do Not Disturb" on their doors. (3/P/T)
29/1/1	F3-20.	Even if a door is open, staff should not enter a resident's room without permission. (3/P/T)
29/2/0	F4-19.	Nursing homes should provide adequate privacy for residents who desire to be alone, either by themselves or as a couple. (3/P/T)
21/9/2	F1-22.	Sexual activity improves an older person's quality of life. (4/K/T)
25/5/1	F2-14.	Sexual expression among the elderly promotes a sense of well-being. (4/K/T)
18/11/2	F3-21.	People in intimate relationships live longer than those who are not. (4/K/T)
27/2/2	F4-20.	Sexual expression can relieve stress among the elderly. (4/K/T)
27/3/1	F4-21.	Loneliness is the most difficult part of being old. (4/K/T)
16/13/2	F4-22.	Older people who are sexually active are less likely to commit suicide. (4/K/T)
11/19/1	F3-22.	It is not the staff's responsibility to worry about older people's sexual needs. (4/A/F)
3/28/1	F1-23.	Sexual expression is not important for old people. (4/A/F)
2/28/1	F2-15.	Sex is meant for reproduction not for pleasure. (4/A/F)
9/20/3	F1-24.	Staff should encourage relationships between residents. (4/P/T)
13/17/1	F2-16.	It is not the staff's responsibility to encourage friendships between the residents. (4/P/T)
19/11/1	F3-23.	Staff are responsible for providing residents with opportunities for expression of intimacy and sexual needs. (4/P/T)
26/4/2	F1-25.	Staff cannot assume a person is competent or incompetent. (5/K/T)
23/7/1	F2-17.	When it comes to resident sexuality, staff must judge each situation individually. (5/K/T)
16/13/2	F3-24.	It is not always clear whether sexual behavior is consensual or not. (5/K/T)
17/10/4	F4-23.	It is not easy to tell the difference between sexual abuse and consensual sex when people have dementia. (5/K/T)
17/11/4	F1-26.	A resident with dementia should not have sex because he or she cannot consent. (5/A/F)
14/15/2	F2-18.	A person who is not mentally competent should not be allowed to get romantically involved with another person. (5/A/F)
10/20/1	F3-25.	A person with dementia should not be having sex. (5/A/F)
32/0/0	F1-27.	Staff are responsible for protecting the residents from sexual abuse. (5/P/T)
19/10/2	F2-19.	Staff should stay out of reach of a demented resident who tries to pinch them. (5/P/T)
29/2/0	F3-26.	Staff should allow mentally competent consenting residents to make their own decisions about sexual expression. (5/P/T)
18/9/4	F4-24.	If a person with dementia makes sexual advances toward a staff member, the staff member should report him or her immediately. (5/P/F)

A/D/NR	A/D/NR	Form Item and answer key
4/24/3	F4-25.	A staff member should stop any two residents who are having sexual intercourse. (5/P/F)
9/14/8	F2-20.	Older women rarely masturbate. (6/K/F)
17/6/8	F2-21.	Masturbation is a common type of sexual behavior among older people. (6/K/T)
3/24/4	F3-27.	Excessive masturbation may bring about an early onset of mental confusion and dementia in the aged. (6/K/F)
14/10/7	F4-26.	Masturbation is a common activity among older women. (6/K/T)
20/5/6	F4-27.	Masturbation in older men and women has beneficial effects. (6/K/T)
23/5/4	F1-28.	Masturbation is an acceptable sexual activity for older women. (6/A/T)
19/8/5	F1-29.	I believe that masturbation is a good way to satisfy sexual needs in the elderly [who are alone] who do not have partners. (6/A/T)
2/26/4	F1-30.	Masturbation is a dangerous practice and should be stopped. (6/A/F)
22/3/6	F2-22.	Masturbation is a convenient way to satisfy sexual needs. (6/A/T)
29/1/1	F3-28.	Masturbation is an acceptable sexual activity for older men. (6/A/T)
4/28/2	F4-28.	Masturbation is a disgusting practice. (6/A/F)
27/2/3	F1-31.	Staff should take a resident who is masturbating in public someplace where he or she can have privacy. (6/P/T)
2/25/4	F2-23	Staff should stop anyone they find masturbating. (6/P/F)
16/10/5	F3-29.	It is appropriate for a doctor or nurse to suggest masturbation to a patient. (6/P/T)
15/13/4	F1-32.	People in their 30s and 40s are more sexually active than people in their 60s and 70s. (7/K/T)
5/19/7	F2-24	Older African Americans are more likely to be promiscuous than older whites. (7/K/F)
11/14/6	F4-29.	People in their 70s have very different sexual needs than people in their 80s or 90s. (7/K/F)
29/0/2	F3-30.	Some religions have strict rules about sexual behavior. (7/K/T)
1/30/1	F1-33	Sex between older people of different races is wrong. (7/A/F)
3/27/1	F2-25	It is immoral for older people to have sex purely for enjoyment. (7/A/F)
13/13/5	F2-26.	Homosexuality is a sin. (7/A/F)
23/4/4	F2-27.	It is okay for an older woman to have a relationship with a much younger man. (7/A/T)
2/29/0	F3-31.	Interest in sex is not normal for older people. (7/A/F)
2/28/1	F4-30.	I cannot imagine an older person having sex. (7/A/F)
25/3/3	F4-31.	It is okay for an older man to have a relationship with a much younger woman. (7/A/T)
2/27/3	F1-34.	Staff should discourage intimate relationships between people of different races. (7/P/F)
3/26/2	F2-28.	Staff should share their beliefs about sexuality with the residents. (7/P/F)
26/2/4	F1-35.	Homosexual relationships involve more than just sex. (8/K/T)
16/10/5	F2-29.	It is unlikely that an older heterosexual person will form a homosexual relationship for the first time. (8/K/T)
24/7/0	F3-32.	Homosexuality is not an illness or a disease. (8/K/T)
17/10/5	F1-36.	Homosexuality is unnatural. (8/A/F)
8/19/4	F2-30	Expression of affection between two women is disgusting. (8/A/F)
7/23/1	F3-33.	I would be able to tell if someone I knew was a homosexual. (8/A/F)
20/9/2	F4-32.	It is okay for an older person to be a gay or lesbian. (8/A/T)
14/14/3	F4-33.	Caregivers need to know whether the residents are gay or lesbian. (8/A/F)
12/16/3	F4-34.	Expressions of affection between two men are disgusting. (8/A/F)
28/1/3	F1-37.	Staff should not make judgments about an older person's sexuality. (8/P/T)
21/7/3	F2-31.	Staff should respect the gay or lesbian residents' right to privacy. (8/P/T)

A/D/NR	A/D/NR	Form Item and answer key
4/27/0	F3-34.	We should not allow gays and lesbians to live at our facility. (8/P/F)
24/5/3	F1-38.	The family is sometimes concerned about inheritance problems if a parent develops an intimate relationship with a new partner. (9/K/T)
19/10/2	F2-32.	Most children assume an elderly parent will have no interest in remarriage or finding romance after they become widowed. (9/K/T)
15/16/0	F3-35.	Most family members want to be notified if one of their parents is having a sexual relationship with another resident. (9/K/T)
15/10/6	F4-35.	Family members often prevent sexual expression by elderly people in long-term care. (9/K/T)
4/25/3	F1-39.	I cannot imagine my parents having sex. (9/A/F)
8/20/3	F2-33.	Family members have the right to know about their relatives' relationships when they are paying the bills. (9/A/F)
16/13/2	F3-36.	There are too problems related to money and inheritance when older people remarry. (9/A/F)
25/4/2	F4-36.	I would want my spouse to remarry or have sex if I died. (9/A/T) 44
10/20/1	F2-34.	Staff should separate men and women living in institutions to avoid problems for staff and criticism by families. (9/P/F)
8/23/0	F3-37.	Staff should call family members if the resident becomes involved in an intimate relationship. (9/P/F)
24/5/2	F4-37.	Family members should allow a mentally competent consenting resident to make their own decisions about sexual expression. (9/P/T)
1/30/1	F3-38.	People who have recently lost a spouse may be emotionally vulnerable. (10/K/T)
9/16/7	F1-40.	Older single men are often afraid of intimacy with a new partner. (10/K/T)
16/11/4	F4-38.	Most single older people would like to be married. (10/K/T)
16/8/7	F2-35.	Older single [widowed] men are often eager for intimacy with a new partner. (10/K/T)
1/30/0	F3-38.	It is ridiculous for an older woman to become involved romantically with a younger man. (10/A/F)
9/21/2	F1-41.	It is easier for an older man to begin a new relationship than for an older woman. (10/A/T)
20/9/2	F2-36.	It is acceptable for older people to have sexual relationships without being married. (10/A/T)
5/24/2	F2-37.	Older people should not develop a new relationship for at least a year after the death of a spouse. (10/A/F)
15/10/6	F4-39.	The extreme shortage of older men is a hardship for older women. (10/A/T)
18/11/3	F1-42.	Adult children should encourage their parents to have and express sexual feelings. (10/P/T)
11/19/1	F2-38.	Staff should notify the family if a resident becomes involved romantically with another resident. (10/P/F)
3/27/1	F3-39.	No one should encourage an older person to remarry after the death of a spouse. (10/P/F)
15/12/4	F4-40.	Staff should let the family know about a residents' visitors. (10/P/F)

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